

Medicare Savings Program

Louisiana's Medicare Savings Program helps pay your Medicare premium and may pay your Medicare co-pays and deductibles. This program will not cost you anything. It does not cover medicine.

How to Apply

- ❖ **Online** –
www.Medicaid.DHH.Louisiana.gov
- ❖ **Mail** – Mail the application and documents of proof to:
**Medicare Savings Program
P.O. Box 91278
Baton Rouge, LA 70821-9278**
- ❖ **FAX** – Fax the application and documents of proof to:
1-877-523-2987 (toll free)
- ❖ **Drop Off** – Drop off the application and documents of proof at your local Medicaid office. To find the closest office call us at **1-888-342-6207**, or visit www.Medicaid.DHH.Louisiana.gov.

To Qualify

- ❖ You must have Medicare Hospital Insurance (Part A) or be eligible to get it. Look on your Medicare card or call Social Security toll free at 1-800-772-1213 if you are not sure.
- ❖ Your income needs to be less than \$867 single or \$1167 married for us to pay your Medicare premium, co-pays, and deductibles.

- ❖ Your income needs to be less than \$1170 single or \$1575 married for us to pay only your Medicare premium.

The income amounts go up every April. If your income is more than these amounts, you may still qualify. It is best to apply.

- ❖ The things you own must be worth less than \$4,000 if you are single or \$6,000 if you are married.

We count things like bank accounts, vehicles, and extra property. **(One vehicle and home property is not counted.)**

After We Get Your Application

We will check your application and let you know if we need anything else. Once we have everything we need, we will make a decision as fast as we can. We will send you a letter to let you know if you qualify. If you qualify, your case will be reviewed every year.

The information you give us on your application and everything you send us will be kept confidential. We are required by law to keep it private.

Help with Prescriptions

To find out about Medicare's Prescription Drug Plan, call 1-800-633-4227. If you are deaf or hard of hearing **and** have a TTY text telephone, call 1-877-486-2048.

Your Rights

If you think the decision we make is unfair, not correct or made too late, you may ask for a Fair Hearing.

- ❖ Call the Medicare Savings Program office at 1-888-342-6207; and/or
- ❖ Write to
LA DHH Bureau of Appeals
P. O. Box 4183
Baton Rouge, LA 70821-4183

Medicaid is an equal opportunity program. We can't treat you differently because of your race, color, sex, age, disability, religion, nationality or political beliefs. If you think we have:

- ❖ Call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019;
- ❖ Call or write to your local Medicaid office; and/or
- ❖ Write to:
LA Department of Health & Hospitals
P.O. Box 4818
Baton Rouge, LA 70821-4818

¿Necesita traductor de español?
Llame al 1-877-252-2447.

Quý vị có cần thông dịch viên
người Việt không? Nếu cần xin
gọi số
1-877-252-2447.

This public document was published at a total cost of \$7,500.00. Fifty thousand (50,000) copies of this public document were published in this first printing at a cost of \$22,500.00. The total cost of all printings of this document, including reprints, is \$7,500.00. This document was published by Office of State Printing, 950 Brickyard Lane, Baton Rouge, LA 70804 to advise applicants, recipients and other individuals of Medicare Savings coverage available through the Medicaid Program under authority of 42 CFR 435.905 (a)(1). This material was printed in accordance with the standards for printing by state agencies established pursuant to R.S. 43:31. This material was printed according to standards for printing by State agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with provisions of Title 43 of the Louisiana Revised Statutes.



BHSF Form 1-MB Cover
Rev. 10/08
Prior Issue Obsolete

Application for Louisiana Medicaid's



Get Help with
Medicare Premiums,
Co-pays, &
Deductibles

1-888-544-7996

www.MSP.DHH.Louisiana.gov

Louisiana Medicaid Medicare Savings Program Application

Use this application to apply for Medicaid to pay your Medicare premiums, co-pays, and/or deductibles. **You must have or be eligible to get Medicare Part A to get this type of Medicaid.** This is a free program. It does not cover medicine.

To apply using this application:

1. **Fill out and sign with a black ink pen.**
2. **Send us the application and proof of income and health insurance.**

Please trust that the information you give us on this application and everything you send us will be kept confidential. We are required by law to keep it private.

★★★★★★★★★
Questions? Need Help?
Call 1-877-252-2447
TTY Text Telephone for the
Hearing Impaired,
Call 1-800-220-5404
★★★★★★★★★

What language do you speak best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____
What language do you write best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

1. Where did you get this application form?

- ☐ Medicaid Office ☐ Hospital ☐ Pharmacy ☐ Doctor's Office ☐ Friend/Relative
☐ Internet ☐ Food Stamps Office ☐ Health Unit ☐ Social Security Office
☐ Business (Store, Work) ☐ Festival/Health Fair ☐ Other _____

2. Tell us about you (the person applying).

Name _____ ☐ Male ☐ Female
First Middle Initial Last

Social Security Number _____ Date of Birth (month, day, year) _____

☐ Married and living with spouse ☐ Single ☐ Divorced ☐ Widow/Widower

Race/Ethnic Background: (You do not have to answer. You may mark one or more.)

- ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander

3. Tell us how to reach you.

Mailing Address _____ Apt/Lot _____

City _____ State _____ Zip Code _____

Home Address (if different) _____

City _____ State _____ Zip Code _____

Home Phone () Cell Phone ()
 Parish You Live In
 Best Day and Time to Call Between Hours of 8 a.m. and 4:30 p.m. M-F
 Email Address

4. If you are married and living with your spouse, tell us about them in the spaces below. ☐ No Spouse Lives With You - Go to Question 5

Name (first, middle initial, last) ☐ Male ☐ Female
 Date of Birth (month, day, year) Social Security Number

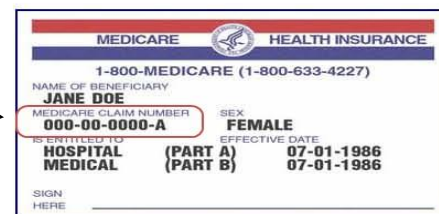
Does your spouse want to apply for the Medicare Savings Program? ☐ Yes - Fill Out Below ☐ No - Go to Question 5

Spouse's Race/Ethnic Background: (You do not have to answer. You may mark one or more.) ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native
☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander

5. Medicare

Your Medicare Claim Number (from Medicare card)

Your Spouse's Medicare Claim Number (from Medicare card)



6. Do you have health insurance or a Medicare supplement?

☐ Yes – Fill out below ☐ No Insurance - Go to Question 7

If there is more than one insurance, use another sheet of paper.

Who is covered? ☐ You ☐ Spouse ☐ Both Policyholders' Name

Coverage Start Date How much does it cost for the month?

Insurance Company Name and Phone Number

Policy Number Group Number

What does it cover? ☐ Hospital ☐ Doctor ☐ Medicine ☐ Dental ☐ Ambulance

7. Does anyone work? ☐ Yes – Fill Out Below ☐ No – Go to Question 8

Who works?	List Employer & Phone # or Write Self-Employed	How much is paid? (show gross income, before deductions)	How often paid? (weekly, every 2 weeks, monthly)

8. Does anyone get income (money) from:

- Social Security • SSI • Veterans' Benefits • Retirement • Pension • Royalties
- Annuities • Rent from Property Owned • Alimony • Worker's Comp
- Unemployment • Money from Friends/Relatives • Other (tell us what it is)

☐ Yes - Fill Out Below ☐ No - Go to Question 9

Who gets it?	What is it?	How much? (show gross income, before deductions)	How often? (weekly, every 2 weeks, monthly)

9. Has anyone applied for income such as Social Security or Veterans' benefits, but they did not get it, yet? ☐ Yes - Fill Out Below ☐ No - Go to Question 10

Who? _____ What is it? _____

**10. Has anyone applying ever received SSI (Supplemental Security Income)?
If yes, who? _____**

11. Do you or your spouse own a car, truck, boat, or other vehicle? ☐ Yes - Fill Out Below ☐ No - Go to Question 12 *If more than 3, use another sheet of paper.*

Owner(s)	Year	Make	Model	Value	Amount Owed
				\$	\$
				\$	\$
				\$	\$

12. Does anyone have any of the things listed below? If Yes, give us the following information.

Item	Company Name, Bank Name, Phone Number; and/or Description	Account/ Policy Number	Who does it belong to?	What is the value?
Checking Account <input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Savings Account <input type="checkbox"/> Yes <input type="checkbox"/> No				\$

Item	Company Name, Bank Name, Phone Number; and/or Description	Account/ Policy Number	Who does it belong to?	What is the value?
Trust Funds/ Stocks/Bonds <input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Annuities, Retirement accounts <input type="checkbox"/> Yes <input type="checkbox"/> No (IRA, Keogh, 401-K)				\$
Funeral/Burial Plans <input type="checkbox"/> Yes <input type="checkbox"/> No (bank account, pre-need, burial contract with funeral home, etc.)				\$
Other <input type="checkbox"/> Yes <input type="checkbox"/> No (CDs, mineral rights, etc.)				\$

13. Does anyone have any life insurance/burial insurance policies? ☐ Yes - Fill Out Below ☐ No - Go to Question 14 *If more than 2, use another sheet of paper.*

Policy Owner	Person Covered	Insurance Company	Policy Number	Face Value
				\$
				\$

14. Does anyone own property other than home property or have an ownership interest in property (from an inheritance)? ☐ Yes - Fill Out Below ☐ No - Go to Question 15

Address	Owner	Value	Amount Owed
		\$	\$
		\$	\$

15. Does anyone have any medical bills for care or services that were received in the last 3 months? ☐ Yes ☐ No If Yes, what is the amount? _____

This is the end of the application. SIGN BELOW

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I also acknowledge that I have received and read the Rights and Responsibilities below.



Sign Your Name Here: _____ **Date:** _____

If you are married and your spouse is applying, he/she will sign below.



Spouse Signs Here: _____ **Date:** _____

Send Us the Application and These Things

Proof of income for you and your spouse and any health insurance cards, including Medicare supplements.

Where to send the application and proofs.

Mail to: P.O. Box 91278, Baton Rouge, LA 70821-9278

Fax to: 1-877-523-2987 (toll-free)

Drop off at: Your local Medicaid office or Application Center. For the office closest to you, call 1-888-342-6207. If you are deaf or hard of hearing and use a TTY text telephone, call 1-800-220-5404.

YOUR RIGHTS AND RESPONSIBILITIES

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) changes in mailing or home address; 3) when someone moves in or out of the home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things owned by anyone who gets Medicaid who is disabled or over age 64.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

IMPORTANT PHONE NUMBERS		
	PHONE NUMBER	TTY TEXT TELEPHONE
Medicaid Services	1-888-342-6207	1-800-220-5404
Medicare	1-800-MEDICARE (1-800-633-4227)	1-877-486-2048

IMPORTANT WEB SITES	
Other Medicaid Programs	<u>www.Medicaid.DHH.Louisiana.gov</u>
Apply for or Renew Your Medicaid	<u>www.Medicaid.DHH.Louisiana.gov</u>